General

Guideline Title

Breastfeeding-friendly physician's office: optimizing care for infants and children, revised 2013.

Bibliographic Source(s)

Grawey AE, Marinelli KA, Holmes AV, Academy of Breastfeeding Medicine. ABM clinical protocol #14: breastfeeding-friendly physician's office: optimizing care for infants and children, revised 2013. Breastfeed Med. 2013 Apr;8(2):237-42. [51 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #14: breastfeeding-friendly physician's office, part 1: optimizing care for infants and children. Breastfeed Med. 2006 Summer;1(2):115-9.

Recommendations

Major Recommendations

Definitions for the quality of evidence (I-III) are provided at the end of the "Major Recommendations" field.

Recommendations

1. Establish a written breastfeeding-friendly office policy (Philipp & Academy of Breastfeeding Medicine Protocol Committee, 2010; Cardoso et al., 2008; UNICEF Breastfeeding Initiatives Exchange, 2013). Collaborate with colleagues and office staff during development. Inform all new staff about the policy. Provide copies of your practice's policy to hospitals, physicians, and all healthcare professionals covering your practice for you. (III)
2. Offer culturally and ethnically competent care (Section on Breastfeeding, 2012). Understand that families may follow cultural practices regarding discarding of colostrum, maternal diet during lactation, and early introduction of solid foods. Provide access to a multilingual staff, medical interpreters, and ethnically diverse educational material as needed within your practice. (III)
3. If providing antenatal care for the mother, introduce the subject of infant feeding in the first trimester and continue to express your support of breastfeeding throughout the course of the pregnancy. If you are a physician providing postnatal care for the infant, you can offer a prenatal visit to become acquainted with the family during which your commitment to breastfeeding can be shown (Lu et al., 2001; Szucs, Miracle, & Rosenman, 2009; de Oliveira, Camacho, & Tedstone, 2003). Use open-ended questions, such as "What have you heard about breastfeeding?," to inquire about a feeding plan for this child. Provide educational material that highlights the many ways in which breastfeeding is superior to formula feeding. Encourage attendance of both parents at prenatal breastfeeding classes. Direct education and educational material to all family members involved in childcare (father, grandparents, etc.) (Bentley et al., 1999; Labarere et al., 2005; Wolfberg et al., 2004). The father of the infant is particularly important in support of the mother (Wolfberg et al., 2004). Identify patients

with lactation risk factors (such as flat or inverted nipples, history of breast surgery, no increase in breast size during pregnancy, previous unsuccessful breastfeeding experience) to enable individual breastfeeding care for her particular situation. (I, II-1, II-2, II-3, III)

4. Physician interaction with the breastfeeding dyad in the immediate postpartum period depends on the system of healthcare and insurance systems in his or her country. For example, if you are in a system in which you can see the infants while in-hospital, you can collaborate with local hospitals and maternity care professionals in your community (Philipp & Academy of Breastfeeding Medicine Protocol Committee, 2010; DiGirolamo, Gummer-Strawn, & Stein, 2008; Section on Breastfeeding, 2012), providing your office policies on breastfeeding initiation within the first hour after birth to delivery rooms and newborn units. Leave orders in the hospital or birthing facility not to give formula/sterile water/glucose water to a breastfeeding infant without specific medical orders and not to dispense commercial discharge bags containing infant formula, formula coupons, and/or feeding bottles to mothers (Rosenberg et al., 2008; Howard et al., 2000). Show support for breastfeeding during hospital rounds. Help mothers initiate and continue breastfeeding. Counsel mothers to follow their infant's states of alertness as they relate to hunger and satiety cues and ensure that the infant breastfeeds 8–12 times in 24 hours (Kandiah, Burian, & Amend, 2011). Encourage rooming-in and breastfeeding on demand. (I, II-2, III) If you are in a system in which hospital staff members are responsible for the care of the newborns in the hospital and outside physicians do not give orders to hospital staff, you will not be able to see babies and offer support to the mothers until after discharge (see Recommendation 6). However, in many countries hospitals will have received Baby-Friendly Hospital training where mothers should receive good support while inpatients.
5. Encourage breastfeeding mothers to feed newborns only human milk and to avoid offering supplemental formula, glucose water, or other liquids unless medically indicated (Section on Breastfeeding, 2012; Academy of Breastfeeding Medicine Protocol Committee, 2009). Advise the mother not to offer a bottle or a pacifier/dummy until breastfeeding is well established (Howard et al., 2003; O'Connor et al., 2009). (I, III)
6. In many areas of the world, the first follow-up visit will be done by non-physician healthcare workers (Paul et al., 2012). In most European countries midwives care for the mother and infant in the days and weeks after discharge from the hospital. In Germany, for example, every mother and infant has the right to a midwife (often up to 8 weeks of daily visits) covered by insurance. Mothers contact their pediatrician within the first 3 weeks of delivery for the infant's first check-up, which is covered by insurance. In this system, this is the first opportunity the pediatrician has to support breastfeeding. In other countries, such as Australia and New Zealand, routine medical care of infants is undertaken by general practitioners (family physicians), and infants may never visit a pediatrician. In countries such as the United States, where the postpartum care of the mother and infant is done by physicians or physician extenders (for example, physician assistants, nurse practitioners), schedule a first infant follow-up visit 48–72 hours after hospital discharge or earlier if breastfeeding-related problems, such as excessive weight loss (>7%) or jaundice, are present at the time of hospital discharge (Section on Breastfeeding, 2012; Academy of Breastfeeding Medicine Protocol Committee, 2009; American Academy of Pediatrics Subcommittee on Hyperbilirubinemia, 2004). (In cultures or medical situations in which the dyad has remained hospitalized for long enough that weight gain and parental confidence are established prior to hospital discharge, follow-up may be deferred until 1–2 weeks of age if otherwise appropriate. For example, in Japan the dyad usually stays in hospital for 5–6 days after childbirth. The Japanese Pediatric Society recommends the first visit to the pediatrician 1 week after discharge, when the infant is about 2 weeks old.) Ensure there is access to a lactation consultant/educator or other healthcare professional trained to address breastfeeding questions or concerns during this visit. Advise the mother that feeding will be observed during the visit so that she can let staff know if the infant is ready to breastfeed while she is waiting. Provide comfortable seating, privacy, and a nursing pillow as needed for the breastfeeding dyad to facilitate an adequate evaluation. Begin by asking parents open-ended questions, such as "How is breastfeeding going?," and then focus on their concerns. Take the time to address the many questions that a mother may have. Assess latch and successful and adequate milk transfer at the early follow-up visit. Identify lactation risk factors and assess the infant's weight, hydration, jaundice, feeding activity, and output. Provide medical help for women with sore nipples or other maternal health problems that may impact breastfeeding. Provide close follow-up until the parents feel confident and the infant is doing well with adequate weight gain by the World Health Organization (WHO) Child Growth Standards ("WHO Child Growth Standard," 2013). (III)
7. Ensure availability of appropriate educational resources for parents. In accordance with the WHO International Code of Marketing of Breastmilk Substitutes (WHO, 1981), educational material should be noncommercial and should not advertise human milk substitutes, bottles, or nipples/teats (Howard et al., 2000). Educational resources may be in the form of handouts, pictures, books, and DVDs. Recommended topics for educational material can include growth patterns, feeding and sleep patterns of breastfed babies, management of growth spurts, recognition of hunger and satiety cues, positioning and attachment, management of sore nipples, mastitis, low supply, blocked ducts, engorgement, reflux, normal stool and voiding patterns, maintaining lactation when separated from the infant (for example, during illness, prematurity, or return to work), breastfeeding in public, postpartum depression, maternal medication use, and maternal illness during breastfeeding. (I)
8. Allow and encourage breastfeeding in the waiting room. Display signs in the waiting area encouraging mothers to breastfeed (see Figures 1 and 2 in the original guideline document). Provide a comfortable private area to breastfeed for those mothers who prefer privacy (Lu et al., 2001; Bunik et al., 2010; Shariff et al., 2000; Cardoso et al., 2008). Do not interrupt or discourage breastfeeding in the office. (II-2, II-3)
9. Ensure an office environment that demonstrates breastfeeding promotion and support. Eliminate the practice of distribution of free formula and baby items from formula companies to parents (Rosenberg et al., 2008; Howard et al., 2000). In accordance with the WHO Code

(WHO, 1981), store formula supplies out of view of parents. Display noncommercial posters, pamphlets, pictures, and photographs of breastfeeding mothers in your office (Bentley et al., 1999; Shariff et al., 2000; Cardoso et al., 2008). Do not display images of infants bottle-feeding. Do not accept gifts (including writing pads, pens, or calendars) or personal samples from companies manufacturing infant formula, feeding bottles, or pacifiers/dummies (WHO, 1981). Specifically target educational material to populations with low breastfeeding rates in your practice. (II-2, II-3)

10. Develop and follow telephone triage protocols to address breastfeeding concerns and problems (Bunik et al., 2010; Pugh et al., 2010; Bunik, 2012). Conduct follow-up phone calls to assist breastfeeding mothers. Provide readily accessible resources like books and protocols to triage nurses (see Table 1 in the original guideline document). (I)
11. Commend breastfeeding mothers during each visit for choosing and continuing breastfeeding. Provide breastfeeding anticipatory guidance, give educational handouts, and discuss breastfeeding goals at routine periodic health maintenance visits. Encourage fathers of infants and other infant caregivers to accompany the mother and infant to office visits (Taveras et al., 2003; Taveras et al., "Opinions," 2004; Taveras et al., "Mothers," 2004; Renfrew et al., 2012; Wolfberg et al., 2004). (I, II-1, II-2, II-3)
12. Encourage mothers to exclusively breastfeed for 6 months and to continue breastfeeding with complementary foods until at least 24 months and thereafter as long as mutually desired. Discuss the introduction of solid food at 6 months of age, emphasizing the need for high-iron solids and recommend supplementing vitamins (for example, vitamin D, K, or A) in accordance with published standards (Section on Breastfeeding, 2012), which vary depending on recommendations of the medical society of the country of practice. (III)
13. Set an example for your patients and community. Have a written breastfeeding employee policy and provide a lactation room with supplies for your employees who breastfeed or express milk at work (Philipp & Academy of Breastfeeding Medicine Protocol Committee, 2010; U.S. Department of Health and Human Services [USDHHS], 2013; Ortiz, McGilligan, & Kelly, 2004). (II-2, III) For countries with long paid maternity leaves (for example, 12 months in Germany), this may not be as relevant as for countries with no or short paid maternity leaves.
14. Acquire or maintain a list of community resources (for example, breast pump rental locations) and be knowledgeable about referral procedures. Refer expectant and new parents to peer, community support, and resource groups. Identify local breastfeeding specialists, know their background and training, and develop working relationships for additional assistance. Support local breastfeeding support groups (Witt et al., 2012; Thurman & Allen, 2008; Paul et al., 2012; World Health Assembly, 2003; Chapman et al., 2010). (I, II-3, III)
15. Support and advocate for health policy that incorporates the costs of breastfeeding care into routine health services in those countries in which it is not. These costs also include consultation and equipment that may be needed for particular clinical situations.
16. Where laws exist, enforce workplace laws that support breastfeeding. Where laws do not exist, encourage employers and daycare providers to support breastfeeding (USDHHS, 2013; Ortiz, McGilligan, & Kelly, 2004). Web sites are available to provide material to help motivate and guide employers in providing lactation support in the workplace (USDHHS, 2013). (II-2, III)
17. All clinical physicians should receive education regarding breastfeeding, beginning in the preclinical years (Labarere et al., 2005; Freed et al., 1995; O'Connor, Brown, & Lewin, 2011; Hillenbrand & Larsen, 2002; Feldman-Winter et al., 2008; Feldman-Winter et al., 2010). Areas of suggested education include the risks of artificial feeding, the physiology of lactation, management of common breastfeeding problems, and medical contraindications to breastfeeding. Make available educational resources for quick reference by healthcare professionals in your practice (books, protocols, Web links, etc. [see Table 1 in the original guideline document]). Staff education and training should be provided to all, including front office staff, nurses, and medical assistants. Identify one or more breastfeeding resource personnel on staff. In countries where the practice model makes it possible, consider employing a lactation consultant or a nurse trained in lactation. If this is not possible, network with other professionals and participate in local perinatal networks as available and appropriate to your location (Witt et al., 2012; Thurman & Allen, 2008; Paul et al., 2012). (I, II-2, II-3)
18. Volunteer to let medical students and residents rotate in your practice. Participate in medical student and resident physician education. Encourage establishment of formal training programs in lactation for current and future healthcare providers (Freed et al., 1995; O'Connor, Brown, & Lewin, 2011; Hillenbrand & Larsen, 2002; Feldman-Winter et al., 2008; Feldman-Winter et al., 2010). (II-2, II-3)
19. Track breastfeeding initiation and duration rates in your practice and learn about breastfeeding rates in your community.

Definitions:

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Infant health/nutrition

Guideline Category

Counseling

Evaluation

Management

Clinical Specialty

Family Practice

Nursing

Nutrition

Obstetrics and Gynecology

Pediatrics

Intended Users

Advanced Practice Nurses

Dietitians

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

- To provide recommendations for a "Breastfeeding-Friendly Practice" through a combination of a conducive office environment and education of health care professionals, office staff, and families
- To develop a clinical protocol for managing common medical problems that may impact breastfeeding success

Target Population

The breastfeeding dyad, both the mother antepartum and the dyad postpartum

Interventions and Practices Considered

1. Establishing a written breastfeeding-friendly office policy to be provided to physicians, hospitals, and office staff
2. Culturally and ethnically competent care
3. Introduction of the subject of infant feeding in the first trimester and support of breastfeeding throughout the course of the pregnancy
4. Physician interaction with the breastfeeding dyad in the immediate postpartum period, if possible
5. Appropriate educational resources (noncommercial) for patients (e.g., handouts, pictures, books, and DVDs)
6. Encouraging attendance of both parents at prenatal breastfeeding classes
7. Encouragement of exclusive breastfeeding and avoidance of supplemental formula, glucose, or other liquids
8. Identification of patients with lactation risk
9. Infant follow-up visit 48–72 hours after hospital discharge or earlier if breastfeeding-related problems
10. Assessment of the infant's weight, hydration, jaundice, feeding activity, and output
11. Ensuring a supportive office environment and positive feedback for breastfeeding mothers
12. Medical help for women with maternal health problems that may impact breastfeeding and follow-up until parents feel confident and the infant is doing well with adequate weight gain
13. Telephone triage protocols to address breastfeeding concerns and problems
14. Maintaining a list of community resources (e.g., breast pump rental locations) and knowledge of referral procedures
15. Staff and student education regarding breastfeeding
16. Tracking breastfeeding initiation and duration rates

Major Outcomes Considered

- Rates and duration of breastfeeding initiation and exclusivity
- Duration of non-formula feeding after the introduction of complementary foods

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

General Methods

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance.

Specific Methods

The search was conducted using PubMed. In addition, a search of the original references and literature searches (from the previous version) were used to look for additional supportive articles. The time frame for the literature search was January 1992 to December 2012. The inclusion criteria used for the searched were: humans, review articles, primary research articles, and English. The specific search terms used were: breastfeeding, primary care, physician, pediatrician, obstetrician, family physician.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

I Evidence obtained from at least one properly randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, is submitted by the expert panel to the Protocol Committee.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Expert consensus from systematic review with evidence tables

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The draft protocol is peer reviewed by individuals outside of contributing author/expert panel, including specific review for international applicability. The Protocol Committee's sub-group of international experts recommends appropriate international reviewers. The Chair and/or protocol resource person institutes and facilitates this process. Reviews are submitted to the committee Chair and resource person.

The contributing author/expert panel and/or designated members of protocol committee work to amend the protocol as needed.

The draft protocol is submitted to the Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three weeks following submission. The Chair, resource person and protocol contributor(s) amend the protocol as needed.

Following all revisions, the protocol has the final review by original contributor(s) to make final suggestions and ascertain whether to maintain contributing authorship.

The final protocol is submitted to the Board of Directors of ABM for approval. A two-thirds majority of Board members' positive vote is required for final approval.

Evidence Supporting the Recommendations

References Supporting the Recommendations

Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #3: hospital guidelines for the use of supplementary feedings in the healthy term breastfed neonate, revised 2009. Breastfeed Med. 2009 Sep;4(3):175-82. PubMed

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Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Improved breastfeeding outcomes for mothers and infants

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

A central goal of The Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Bibliographic Source(s)

Grawey AE, Marinelli KA, Holmes AV, Academy of Breastfeeding Medicine. ABM clinical protocol #14: breastfeeding-friendly physician's office: optimizing care for infants and children, revised 2013. Breastfeed Med. 2013 Apr;8(2):237-42. [51 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 (revised 2013 Apr)

Guideline Developer(s)

Academy of Breastfeeding Medicine - Professional Association

Source(s) of Funding

This work was supported in part by a grant from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services.

Guideline Committee

Academy of Breastfeeding Medicine Protocol Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

None to report

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #14: breastfeeding-friendly physician's office, part 1: optimizing care for infants and children. Breastfeed Med. 2006 Summer;1(2):115-9.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Academy of Breastfeeding Medicine Web site

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Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

Availability of Companion Documents

The following is available:

- Procedure for protocol development. Academy of Breastfeeding Medicine. 2011 Mar. 2 p. Available in Portable Document Format (PDF) from the Academy of Breastfeeding Medicine Web site .

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on November 14, 2007. The information was verified by the guideline developer on October 31, 2008. This NGC summary was updated by ECRI Institute on September 24, 2013. The updated information was verified by the guideline developer on October 4, 2013.

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